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# Thai cultural influences on breastfeeding behaviour

Lesley Dornan<sup>1</sup> BSc, RGN, SCPHN, HV. Marlene Sinclair<sup>2</sup> PhD, MEd, BSc, DASE, RNT, RM, RN. W George Kernohan<sup>3</sup> PhD, BSc. Janine Stockdale<sup>4</sup> PhD, BSc, RM, RN. Varangthip Khuwuthyakorn<sup>5</sup> MD. Pikul Suppasan<sup>6</sup> RN.

1 Health visitor and PhD student, Institute of Nursing and Health Research, University of Ulster, Newtownabbey BT37 0QB Northern Ireland. Email: dornan-L1@email.ulster.ac.uk

2 Professor of midwifery research, Institute of Nursing and Health Research, University of Ulster, Newtownabbey BT37 0QB Northern Ireland. Email: m.sinclair1@ulster.ac.uk

3 Professor of health research, Institute of Nursing and Health Research, University of Ulster, Newtownabbey BT37 0QB Northern Ireland. Email: wg.kernohan@ulster.ac.uk

4 Research fellow, Institute of Nursing and Health Research, University of Ulster, Newtownabbey BT37 0QB Northern Ireland. Email: djstockdale@ulster.ac.uk

5 Instructor, University Division of Neonatology, Department of Pediatrics, Chiang Mai University, Chiang Mai 50200 Thailand. Email: vkasiwat@med.cmu.ac.th

6 Assistant professor, Faculty of Nursing, Chiang Mai University, Chiang Mai 50200 Thailand. Email: psuppas@gmail.com

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## Abstract

**Background.** Breastfeeding is recognised as a complex behaviour which is influenced by many factors. This creates challenges for all breastfeeding mothers and health professionals seeking to support women in their breastfeeding journey. Personal, psychosocial, cultural and economic factors create a complicated interplay which affects breastfeeding practices. Maternal motivation is acknowledged as a determinant of breastfeeding behaviour; however, it is important to recognise that motivation is influenced by the culture and environment in which women live. Understanding how culture influences behaviour offers researchers insight into breastfeeding practices.

**Objectives.** The aim of this study was to identify the contextual and cultural influences that are communicated through breastfeeding instruction within a Thai setting.

**Methods.** Observational data were collected at national, corporate and individual levels using the ARCS educational model (Keller, 2008) and Gardenswartz et al's (2003) cultural model to gain a deeper understanding of key factors influencing breastfeeding education and maternal motivation. A total of 75 hours of observation were completed in eight maternity environments. The data collected included national data profiles, corporate policies, protocols and everyday practices. Ethical approval was obtained from universities in Northern Ireland and Northern Thailand.

**Findings.** Published national breastfeeding rates were 49.6% for initiation and 15% for duration at six months. Breastfeeding policies in seven settings were identified and analysed. These were all based on the Baby Friendly Initiative (BFI) guidelines. Organisational culture was evident in the timing, venue and structure of the breastfeeding classes with individual and group breastfeeding classes prenatally and postnatally and specific self-efficacy and postnatal discharge classes. The maternity staff took pride in what they termed 'The Thai Way' of breastfeeding and this was indicative of a specific cultural identity.

**Conclusion.** This observation of Thai breastfeeding behaviour has demonstrated strong cultural influences as being inextricably linked to individual and national goals. The systematic process of gathering information about the educational and cultural components of breastfeeding behaviour and practices in a Thai setting using a combination of the ARCS model by Keller (2008) and Gardenswartz et al (2003) provided an enriched understanding of the interplay between the individual and societal factors evident in this unique culture.

**Key words:** Breastfeeding, instruction, motivation, context, culture, adaptation, evidence-based midwifery

## Background

Breastfeeding is internationally recommended as being the most effective way to meet an infant's nutritional needs within the first year of life. The WHO advises exclusive breastfeeding up to the age of six months with supplemented breastfeeding to the age of two years (WHO, 2014; 2002). Over 135 million babies are born every year but only 57 million (42%) of these receive breastmilk within the first hour of life, 39% are exclusively breastfed during the first six months and 58% continue breastfeeding up to the age of two years (WHO and UNICEF, 2013). The breastfeeding relationship between mothers and their infants is influenced by personal, psychosocial, sociocultural and circumstantial factors which can affect women's intention, as well as physical challenges during the initiation and continuation of breastfeeding behaviour (Teich et al, 2014; Bai et al, 2011; Brand et al, 2011). The complexity of breastfeeding behaviour can cause complications for health professionals when preparing and supporting women to achieve their breastfeeding goals. A

recurrent theme within breastfeeding literature investigating maternal breastfeeding behaviour is the presence of a support system, which may be either personal or professional (Johnston and Eposito, 2007; Persad and Mensinger, 2007). McInnes et al (2013) have suggested that a paradigm shift is required away from the traditional approach of support and education of individual women, to a more holistic attitude which recognises what influences how the mother and infant learn.

Understanding the context in which women learn to breastfeed is critical when developing a breastfeeding education programme in order to ensure the design and content of the delivery of the material is both relevant and effective. The challenge within a design process is to incorporate cultural sensitivity, appropriateness and the cultural components that are relevant to reduce potential negative influences (Buhi, 2010). A clear understanding of the cultural components that exist within the breastfeeding environment will enable a more integral approach to supporting women. This paper presents the methods and

findings of information gathered to explore the education and cultural factors influencing breastfeeding in Thailand.

### **Aim**

The aim of this paper is to identify contextual and cultural influences in breastfeeding education in a Thai setting.

The objectives are to:

- Explore the policy context for practice
- Identify the key components of current breastfeeding education in a university hospital setting in Thailand
- Map the influence of Thai culture on breastfeeding behaviour.

### **Literature review**

Culture is recognised as being a key component within breastfeeding but one which is relatively unexplored with great diversity reflected between ethnic groups (Fischer and Olsen, 2014; Kelly et al, 2006; Thomas and Avery, 1997). However, the literature rarely provides direction on which essential cultural components need to be identified and considered within the design and development of interventions (Im, 2015). Independent variables of social and cultural significance should be unpacked to identify distinctive cultural elements such as values and behaviours (Whiting, 1976). Dodgeson et al (2002) discovered four patterns of influence on breastfeeding behaviour within an indigenous population: local and mainstream culture, mixed messages received by the mother, life circumstances, and social support. Recognising these varied influences within breastfeeding behaviour as a culturally determined behaviour may go some way to explaining why successful Western style breastfeeding programmes may not be effective in some ethnic groups or culturally diverse situations (Sutton et al, 2007).

Behaviour is not just influenced by the individual's characteristics, but also by their surrounding cultural environments such as family, workplace and geographical area (Unger and Schwartz, 2012; Trickett, 2009). A lack of support during life-changing circumstances, a lack of culturally relevant, timely and comprehensible information and the cultural norms of feeding in public can affect maternal expectations to succeed with breastfeeding (Glover et al, 2009). Family opposition or cultural beliefs and practices may also be a factor (Ong et al, 2014; Ergenekon-Ozelci et al, 2006; Tarrant et al, 2004). In some contexts, religious beliefs appear to play a part in breastfeeding practices; for example, Buddhist teachings in Japan support extended breastfeeding to the age of six as part of their religious teachings (Segawa, 2008; Foo et al, 2005). Traditional postpartum practices in Asian countries are believed to be grounded in two main perspectives: humoral theory (the assumption that the human body is composed of four elements: earth, fire, air and water) and traditional Chinese medicine (Elter et al, 2014; Manderson, 1981). In addition to this, traditional Thai medicine integrates folk medicine, Khmer medicine and Buddhist and animistic beliefs (Elter et al, 2014; del Casino, 2004; Department for the Development of Thai Traditional and Alternative Medicine, 2004; Salguero, 2003; 2007; Bamber, 1999). These cultural influences can all have an effect on maternal motivation.

### **Motivation**

Motivation is defined as the energy and guide that directs behaviour towards achieving a goal (Sansone and Harackiewicz, 2000). Keller (2010) suggested that if a person's motivation is strong enough, there is little that will dissuade them from persisting until they achieve their goal. The application of the ARCS model to routine breastfeeding instruction was first applied to breastfeeding by Stockdale et al, (2014; 2011). When applied to breastfeeding instruction, the ARCS components resulted in a significant increase in maternal motivation to breastfeed through the creation and implementation of a breastfeeding intervention (Stockdale et al, 2008). Therefore, the ARCS was deemed to be an appropriate theoretical frame of reference for undertaking this study and we used Keller's information analysis to guide the data collection and analysis.

A cultural model (Gardenswartz et al, 2003) was adapted and integrated into the information analysis in order to maintain a culturally appropriate as well as a systematic and theoretical framework. While traditionally used within an organisational or conflict management situation, this framework was introduced to ensure clarity in the data collection process, in particular in overcoming potential cross-cultural barriers.

### **Method**

A three-phased approach was used to gather this information:

- Phase 1: National information pertaining to breastfeeding strategies and behaviour
- Phase 2: Corporate information regarding breastfeeding policy and practices within the research setting
- Phase 3: Analysis of the influences of personal cultures of the researcher and Thai health professionals.

### **Setting**

Data collection took place in a university hospital in Northern Thailand, which is a regional referral centre for women and has an approximate birth rate of 2000 per annum. Observations were completed in each context where routine breastfeeding instruction occurred. A convenience sampling approach was implemented and women and staff were offered an explanation of the study and consent forms given prior to each observation session. A total of 75 hours of observation were completed in eight environments of potential breastfeeding instruction.

### **Ethics**

Ethical approval was obtained from Ulster University and Chiang Mai University.

### **Data collection and analysis**

Data were collected using a semi-structured observation schedule and a field diary to gather cultural and contextual, as well as motivational content of routine breastfeeding instruction.

### **Phase 1: National culture**

Data were collated and mapped at a national level. This included a synthesis of national policies and breastfeeding strategies, current national breastfeeding rates and their implications for practice. All health and welfare policies affecting breastfeeding behaviour were identified and mapped. Additional information

was gathered regarding the organisation and implementation of national health services, medical and nursing training and the contribution of professional bodies. The role of the media and messages communicated through the media including magazines, formula advertising on television and radio and messages communicated through popular mediums were also identified and mapped for influence on breastfeeding behaviour.

#### *Phase 2: Organisational culture*

Corporate information relating to breastfeeding policy and practices within the hospital setting was collected during the preparation time prior to and during the observation period. Information was gathered through identifying and mapping all hospital breastfeeding policies, the environments where breastfeeding instruction was offered, the organisational culture and individual roles, responsibilities and practices. Meetings were held at various levels within the hospital with key health professionals and staff to identify potential gaps and challenges related to breastfeeding instruction and hospital organisational culture.

#### *Phase 3: Personal culture*

The importance of intercultural competence is being increasingly recognised across the global spectrum of business, educational organisations, corporations, government and non-governmental organisations as a central requirement for the 21st century (Hammer, 2011). The influence of personal culture had to be recognised and evaluated during the observation process to limit bias and potential cultural miscommunication. Data verification included consultation with the Thai research team for clarity of understanding for cultural influences and values. A Western colleague who had grown up in Thailand and had an in-depth understanding of the language and culture was also consulted.

### **Findings**

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#### *Phase 1: National culture*

Thailand is an upper middle income country in South-East Asia with an estimated population of 67 million most of who are predominantly ethnic Thai (the World Bank, 2013). International health policies such as the millennium development goals and the concept of 'Health for All' policies (WHO, 1998) have been incorporated into national policies to develop a more holistic approach. Thailand, as a member of the WHO, has followed the WHO guidelines in implementing health policy. This has included 'Healthy Thailand' in 2003 and the Universal Healthcare coverage policy in 2001 (Bureau of Policy and Strategy Ministry of Public Health, 2006) which introduced a system of healthcare for all if they have access to a health card known as the 'thirty baht' card. The Healthy Thailand (2004-2008) public health policies, based on WHO recommendations, were implemented to encourage healthy lifestyle choices. These include a vision to enable everyone in Thailand to have access to quality health services and live in a healthy environment (Bureau of Policy and Strategy Ministry of Public Health, 2006).

Set up in 1989, the National Breastfeeding Project established a set of recommendations including the promotion of the Baby Friendly Hospital Initiative (BFI), legislation on access

to maternity leave and the implementation of the Code of Marketing of Breast Milk Substitutes and related products (Hangchaovanich and Voramongkul, 2006). More recent breastfeeding policies include the Thailand Code of Marketing of Foods for Infants and Young Children and Related Products (2008), which is a voluntary agreement to the International Milk Substitute Code (International Baby Food Action Network (IBFAN), 2012; WHO, 1981) and the National Maternal and Child Health Strategy (2008), which combines the Safe Motherhood Programme, BFI and community support programmes (IBFAN, 2012). National surveys completed by the Department of Health and the Ministry of Public Health in 1996, 2000 and 2002 showed increasing rates of breastfeeding in comparison to 1993, but the rates of exclusive breastfeeding to six months remained lower than the government target of 30% by 2006 (Department of Health and Ministry of Public Health 2006; 2002; 2000; 1996; 1994). This target was set by in the Ninth National Development Plan and has now been extended (Department of Health and Ministry of Public Health, 2006).

Breastfeeding rates were reported at 49.6% initiation rate with a 5.4% exclusive breastfeeding rate at six months (World Breastfeeding Trends Initiative, 2010), which reflected one of the lowest exclusive breastfeeding rates in South-East Asia. This information was based on Multiple Indicator Cluster surveys completed in 2006 (National Statistical Office, 2007); however, a more recent report suggested an exclusive breastfeeding rate of 15.10% (Trading Economics, 2014). Data collection in Thailand is collected through a range of systems including government surveys such as hospital project surveys, Family Bonding Reports, Education for All assessments, Multiple Indicator Cluster surveys, Demographic and Health surveys, national household surveys and data from routine reporting systems. These systems are used by the WHO and UNICEF for their data collection as well as the United Nations Population Division. The international statistics are evaluated and adjusted by WHO, UNICEF and UNFPA to account for under-reporting and misclassification. Although Thailand does have some centralised services and documenting services, there are areas where it still appears fragmented, in part due to the range of care offered between the various health services including government, private and university hospitals. A further example of this fragmentation is the implementation of the BFI within the government hospitals, but with more limited implementation within the other sectors. Although Thailand has a voluntary agreement to the **International Code of Marketing Breast Milk Substitutes** formula milk is widely marketed through media outlets including television, commercials, and posters (Phouthakeo et al, 2013). Breastfeeding is still considered the traditional infant-feeding practice in many parts of Thailand, but Thai culture is changing and practices such as 'Yu Duan' (staying at home for a month) and 'Yu Fai' (lying in front of the fire) rituals are diminishing, as well as restrictions for the maternal diet, particularly in urban populations (Kaewsarn and Moyle, 2000). Maternity leave is available by national legislation for up to 14 weeks. Private sector maternity leave allowance is 90 days with 45 days paid by the employer and 45 days covered by Social Security. For government employees,



the entitlement is 90 days by the government and up to 150 days unpaid leave.

### Phase 2: Corporate culture

The next step in the information analysis was the mapping of the corporate culture. This allowed an exploration and analysis of the healthcare context in which the breastfeeding instruction was being given. As suggested by Gardenswartz et al (2003) the following areas were identified and evaluated to inform the contextual and cultural evidence being gathered.

Corporate information was gathered about shared values, beliefs, guiding principles, organisational culture and everyday practice within Chiang Mai University Hospital and the maternity unit.

In the early 2000s, the medical leadership within the paediatric department, which takes responsibility for infant care and breastfeeding education, changed and a new senior doctor was appointed. Within the maternity unit, a high value for breastfeeding was encouraged and supported with multi-professional buy-in. This belief was implemented into a guiding philosophy that breastfeeding is the best option for mothers and babies.

The university hospital was not a recognised Baby Friendly hospital but implemented many of the recommended policies advised by the BFI (Baby Friendly Initiative, 2013) and breastfeeding guidelines and policies were developed and implemented. Traditional Thai culture is very focused on teamwork and all of the changes undertaken were done in consultation with staff. The International Code of Marketing Breast Milk Substitutes was adhered to within the unit, unless it was deemed necessary by medical staff to give formula. Other policies included the Baby Friendly ‘Ten Steps to Successful Breastfeeding’ (WHO and NICE, 2013), which were implemented in the seven instructional environments. These included the training of staff in breastfeeding practices, informing women regarding the benefits and management of breastfeeding, assisting women with initiation of lactation within half an hour of birth and encouraging the practice of rooming in. The *Ten steps to promote and protect breastfeeding for vulnerable infants* (Spatz, 2004) were also implemented in the special baby care units and nurseries.

These policies were observed as everyday practices throughout the observation period in each unit. Breastfeeding and skin to skin, where possible, was encouraged within half an hour of birth. Women were taught within four to six hours of arrival on the postnatal wards how to prepare and massage their breasts and hand express. Assistance was given by nurses when positioning and latching the infants. Twice a day the women gathered in the centre of the ward for teaching sessions with midwives that demonstrated how to apply warm cloths, massage and hand express to help stimulate the milk supply. This was generally done in groups, but if a woman was recovering from surgery, the midwife would assist at the bedside. Breast pumps were available on the ward at any time and rooming in was normal practice on the ward as babies slept with their mothers. An increased level of breastfeeding support was observed in the first two days. An emphasis on breastmilk expression was observed within the unit to help to stimulate and increase milk supply.

Figure 1. Schematic diagram to show evaluation process of corporate organisational culture implemented in this process



The average stay in hospital was three to five days and the impact of this cannot be underestimated. During the last two days in hospital two additional classes were offered to mothers and included the ‘Postnatal Discharge Class’, offering a range of information on breastfeeding, practical care of the mother and baby in the postnatal phase, recognising signs of illness and information on help available on discharge. While care was limited for mothers and babies in the community, paediatric follow-up appointments were given and information was offered regarding the lactation clinic within the unit which women could attend if experiencing breastfeeding problems. A second class, the Breastfeeding Self-Efficacy Class, was also offered between day three and day four. This class was led by nurses from the lactation clinic and was introduced in the unit by the lead nurse in the lactation clinic following an internal research project that examined self-efficacy in breastfeeding mothers in the hospital (not published). This class consisted of one video of a mother explaining her breastfeeding experience and challenges and a second video of the lactation nurse explaining positioning and latch while watching two mothers feeding.

Observation of breastfeeding goals was a key aspect of this study and during the educational classes, these were categorised into:

- Purpose goals – these included messages to women about the reasons why they should consider breastfeeding.
- Target goals – these were specific ways mothers can learn to breastfeed, including positioning and attachment.
- Performance feedback goals – these included confidence in positioning the infant on the breast, evidence of milk flow and supply, wet and dirty nappies.

The self-efficacy classes were designed to build a mother’s confidence in her breastfeeding effort and increase her persistence with the newly learned behaviour.

In this Thai context, the above goals were evident within the classes offered, including the peer support provided, and were visible in the written materials, where there was a strong emphasis on the cultural value of breastfeeding to Thai women and the Thai population. A high value on staff training in breastfeeding instruction and teamwork was also evident in the

analysis and all members of the multiprofessional team were encouraged to attend training both outside and within the hospital and apply it to their practice.

Thai culture values and operates within a hierarchical system and with the implementation of the breastfeeding policies in the early 2000s, the organisational culture also appeared to change. During the observation phase, there were seven settings within the maternity unit where breastfeeding instruction was offered. Within each of these, midwives were appointed as breastfeeding instructors. These midwives took responsibility for both breastfeeding instruction, and with support from human resources, training of staff. As the value of breastfeeding appeared to increase within the unit, many of these midwives appeared to adopt the role of 'breastfeeding champions'. Of note however within this unit, the role of breastfeeding support was not left simply to the breastfeeding champions, but rather adopted by all staff into everyday practices. Annual evaluations were completed by senior nurses and human resources and training needs were identified and addressed. The value placed on breastfeeding was observed through everyday practice as the midwives encouraged and supported mothers both individually and in groups. Breastfeeding was promoted throughout the unit as the best option for infant nutrition, but a pragmatic medical approach was adopted that if an infant required additional nutritional support (formula) it would be prescribed with lactation support to increase maternal milk supply.

### *Phase 3: Individual culture*

It may be argued that for social scientists to fully understand the world they are observing they need to have an understanding of their own individual culture. Gardenswartz et al (2003) suggested that personal culture is made up of the following categories; character, traits, skills, ethnicity, family and personality. Each of these components influence the way individuals view the world around them and how they interpret that world. Throughout the analysis of the cultural elements of this study, it was critical to recognise the influence of the personal culture of the researcher and the cross-cultural team. This included the understanding of how world view may influence perspective. While not a new phenomenon, it was important as a core element of the adapted information analysis for the researcher to reflect and analyse how personal culture may affect the results. Therefore, throughout the observations, field diary notes were taken to attempt to record both individual and cultural observations as a way to increase reflexivity. Bhawuk and Brislin (1992) suggested that to be effective in other cultures, people have to have an interest in alternative cultures, have enough sensitivity to notice cultural differences and be willing to modify their behaviour as an indication of respect for the host culture. This term is known as intercultural sensitivity. Examining personal cultures and identifying the differences between the researcher's personal culture and the host culture was pivotal in contributing to increased understanding and cross-cultural communication. Within that context, it was then possible to build more effective cross-cultural relationships, which enabled trust and openness to be built and to gain insight into other aspects such as

character, personality and the approach to teamwork, as well as ethnicity. An example of this was reflected in the response to the ethical approval process. During the course of ethical approval in the UK, the project was primarily managed by the researcher with support from the research team within the university as is culturally appropriate, whereas in Thailand, the procedure was adopted and owned by the whole Thai research team culminating in the announcement 'our project has been approved' when notified of ethical approval. This cultural attitude had a symbolic influence and required a significant shift of cultural understanding and communication on behalf of the researcher from an individualistic approach to a more collective stance as part of the adaptation development.

Within each step of this process, there was a recognised need for cultural brokering. Jezewski (1990) suggested that cultural brokering is the ability to bridge, link or mediate between groups or persons to affect change between professional and lay people, or between the health professionals, the patient's own community and the broader social system. However, cultural brokering was recognised as a critical component for the success of the cross-cultural adaptation process within this research context. Although the researcher had spent a significant period of time in Thailand, there was still a need for cultural brokering to happen between the Thai research team, the Western research team and the staff and participants who would be involved in the study. Finding common ground, identifying cultural misunderstandings and working to rectify those played a decisive part in building trust and confidence. Reflexivity was required by the researcher and the Thai team to increase cultural understanding. The challenges of communication and preconceived ideas were balanced by the strengths of teamwork, understanding of a common goal and a desire for increased knowledge and wellbeing of breastfeeding mothers.

### **Discussion**

Values are a key element which impact on human motivation at a personal, corporate and national level. They may be considered as socially shared concepts of what is good, right or wrong and are reflected in the symbols, rituals and practices that exist within a country and operate at multiple levels (Sagiv and Schwartz, 2007; Williams, 1970). Values impact on how people perceive, interpret and respond to their world (Rohan, 2000). They also provide researchers with conceptualisations, which allow them to analyse and understand individuals and groups as well as nations and institutions (Knafo et al, 2011). Two seminal theories that exist within value research are those of Schwartz (1999, 1992): the theory of individual values that exist among individuals within cultures and the theory of cultural value orientations which are distinctive between different societies. A further important element of cultural value is the identity found within the culture. Hofstede's (2001, 1980) influential work identifying individualism and collectivism as constructs on opposite poles on a value dimension within world cultures has created an increased interest and renewed debate within social research. As an Asian culture, Thailand would be considered a collective culture with family and elders playing an important role. This cultural value may play an important part in the shift towards a holistic family-centred approach to breastfeeding

(McInnes et al, 2013). Western culture is generally viewed as a more individualistic culture. Individualism was initially used to describe the negative influence of the individual rights on the wellbeing of the commonwealth society, which created a fear that those community values could 'crumble away and be disconnected into the dust and powder of individuality' (Burke, 1973: 109), but Oyserman et al (2002) would argue that this view of individualism describes a world view that is antagonistic to community and collective social structure. Individualism has been defined as having a focus on personal rights above duties, a concern for oneself, their immediate family and their potential, an emphasis on personal autonomy and self-fulfilment and personal accomplishments contributing to or forming the basis of identity (Hofstede, 1980). Waterman (1984) extended this concept into normative individualism with a focus on personal responsibility and freedom of choice with a respect for others. Schwartz (1990) added to this definition by defining individualistic societies as being fundamentally contractual with smaller primary groups and negotiated social relations with specific personal obligations and expectations which conceptualise individualism as a world view that focuses on the personal goals, uniqueness and control (Oyserman et al, 2002).

In a cultural study, the search for these values should be integral to the information-gathering process as it is essential to know and understand the foundations of the culture and how it works in order to identify the cultural elements which are significant within breastfeeding behaviour.

Values which lie at the heart of Thai culture include honour and respect for the monarchy and for the national religion Buddhism. Thailand, similar to Chinese culture, holds a high regard for the family and the tradition of hierarchy, especially towards older family members, and women hold a sense of responsibility and obligation towards family members, seen to arise from the influence of Confucianism (Parks and Chesla, 2007). However this can create additional pressures for Thai women as they face increasing economic pressure to return to work (Yimyam and Hanpa, 2014; Aikawa et al, 2012). An additional pressure is the limited timeframe of maternity leave in an environment where more women are now working outside the house. The breastfeeding policies adopted by the government appear to be evident, including the BFI but the range of hospital services within the healthcare system creates challenges for implementation. The national breastfeeding rates are not particularly high, but it may be argued that a value for breastfeeding is reflected in the ambitious breastfeeding targets. The voluntary agreement of the [Code of Marketing of Breast Milk Substitutes](#) and the influence of the marketing of formula may have an effect on breastfeeding rates as well (IBFAN, 2012). Therefore although the underlying values of the culture may appear to be supportive of breastfeeding, there are significant influences which could affect breastfeeding behaviour and which may result in the varied breastfeeding practices within this culture.

The national and corporate cultural values were evident within the data collection and information analysis process. The establishment of the shared values and beliefs was assisted by meeting with various members of staff within the midwifery

unit, asking strategic questions regarding the start of the breastfeeding programme, the structure of the policies and the guiding philosophies, which allowed a picture to be built of both the organisational culture and the everyday practices of staff within the unit prior to the observation stage of the information analysis. During this stage, the collective nature of the culture and the respect for hierarchy was demonstrated with introductions to each of the heads of department at the beginning of the observations. This was organised by the lead researcher within the Thai team (a neonatologist who facilitated each stage) and the lactation nurse who played a key role in facilitating the information-gathering process. Relationship building continued as an important part of the proceedings and each day, prior to data collection, the researcher would meet and pay respect to the head nurses. This partnership emphasised the value of cultural practices and norms within the research setting. Identifying the roles and relationships between policy-makers, medical staff, midwives and breastfeeding champions assisted with this analysis.

The value placed on breastfeeding was noticeable within the maternity unit. While individual breastfeeding instruction was given, particularly on the postnatal ward regarding position and latch, the women were gathered together by the nurses and instructed in breast massage, preparation of the breast before feeding and breastmilk expression at least twice a day. This was observed in all the postnatal environments. On each occasion, the women were observed to show respect for the nurses, but were also comfortable participating in the instruction within the group. Although the midwives were particularly active in supporting the women in the first two to three days, the women often advised and assisted each other, particularly in the lactation clinic and after the postnatal classes, offering a level of peer support which reflected the collective nature of the culture.

Schwartz (1990) defined collectivist societies as communal societies characterised by diffuse and mutual obligations and expectations related to status. Within these societies, social units hold common goals, fates and values which are centralised (Triandis et al, 1995). Western culture is recognised as being more individualistic, with a focus on individual's choices, goals and rights while Thailand reflects the more Asian value of a collective culture where the choices and values are made on the basis of the wider family and community. Within this hospital setting, breastfeeding was emphasised as a Thai cultural value, particularly within the organisational culture. However, the values were reflected by the individuals as well. The breastfeeding champions appeared to work hard to promote breastfeeding to both the women and staff and there appeared to be a link between the individual values and the collective value of breastfeeding at a staff level. Through the promotion of breastfeeding, training of staff and support for staff and mothers, a value of breastfeeding practice appeared to be modelled from the top down through both the medical and nursing staff. This value and ownership of breastfeeding by the breastfeeding champions and staff resulted in an environment where breastfeeding was the norm as a feeding method. As this occurred, there appeared to be less of an emphasis on individual choices as would be expected in western cultures, and more of an emphasis of the cultural value of breastfeeding.

## Conclusion

The adaptation of the cultural model into a breastfeeding context gave an additional framework to collect, organise and analyse the data at national, corporate and personal levels. While the national culture may have some conflicting consequences, the high value of breastfeeding within the organisational culture was evident in everyday practices. This included the implementation of BFI breastfeeding policies, ownership of the breastfeeding instruction by the staff and a sense of collective purpose and teamwork. Cultural

components played a key part in creating a supportive environment for mothers to begin their breastfeeding experience, meet their breastfeeding goals and overcome potential breastfeeding barriers. The systematic process of gathering information about the educational and cultural components of breastfeeding behaviour and practices in a Thai setting, using a combination of the ARCS model by Keller (2008) and Gardenswartz et al (2003), provided an enriched understanding of the interplay between the individual and societal factors evident in this unique culture.

## References

- Aikawa T, Pavadhgul P, Chongsuwat R, Sawasdivorn S, Boonshuyar C. (2012) Maternal return to paid work and breastfeeding practices in Bangkok, Thailand. *Asia-Pacific Journal of Public Health* 27(2): NP1253-62.
- Bai Y, Wunderlich SM, Fly AD. (2011) Predicting intentions to continue exclusive breastfeeding for six months: a comparison among racial/ethnic groups. *Maternal Child Health Journal* 15(8): 1257-64.
- Bamber S. (1999) Medicine, food and poison in traditional Thai medicine. *Osiris* 13: 339-53.
- Bhawuk DP, Brislin R. (1992) The measurement of cultural sensitivity using the concepts of individualism and collectivism. *International Journal of Intercultural Relations* 16: 413-36.
- Brand F, Kothari MS, Stark MA. (2011) Factors related to breastfeeding discontinuation between hospital discharge and two weeks postpartum. *Journal of Perinatal Education* 20(1): 36-44.
- Buhi K. (2010) Culture and complex interventions: lessons for evidence, policy and practice. *The British Journal of Psychiatry* 197(3): 172-3.
- Burke E. (1973 – original work published 1790) *Reflections on the revolution in France*. Anchor Press: Garden City, NY.
- Butler R. (2000) *What learners want to know: the role of achievement goals in shaping information seeking, learning and interest*. In: Sansone C, Harackiewicz JM. (Eds.). *Intrinsic and extrinsic motivation: the search for optimal motivation and performance*. Academic Press: San Diego: 162-88.
- Deci EL, Ryan RM. (2000) The 'what' and 'why' of goal pursuits: human needs and the self determination of behaviour. *Psychological Inquiry* 11(4): 227-68.
- del Casino VJ. (2004) (Re)placing health and health care: mapping the competing discourses and practices of 'traditional' and 'modern' Thai medicine. *Health and Place* 10(1): 59-73.
- Department for the Development of Thai Traditional and Alternative Medicine. (2004) *Guideline for applying traditional Thai medicine in personal health care*. Veteran Organization: Bangkok.
- Department of Health, Ministry of Public Health. (2006) *Evaluation of the ninth national health plan*. Department of Health, Ministry of Public Health: Bangkok.
- Department of Health, Ministry of Public Health. (2002) *Reproductive health profile*. Department of Health, Ministry of Public Health: Bangkok.
- Department of Health, Ministry of Public Health. (2000) *Situation of Thai children health*. Department of Health, Ministry of Public Health: Bangkok.
- Department of Health, Ministry of Public Health. (1996) *Assessment on feeding pattern of children 0-24 months of age*. Nutrition Division, Ministry of Public Health: Bangkok.
- Department of Health, Ministry of Public Health. (1994) *A study of breastfeeding: a report*. Family Health Division: Bangkok.
- Dodgeson JE, Duckett L, Garwick A, Graham BL. (2002) An ecological perspective of breastfeeding in an indigenous community. *Journal of Nursing Scholarship* 34(3): 235-41.
- Eccles JS, Wigfield A. (2002) Motivational beliefs, values and goals. *Annual Review of Psychology* 53: 109-32.
- Elter PT, Kennedy HP, Chesla CA, Yimam S. (2014) Spiritual healing practices among rural postpartum Thai women. *Journal of Transcultural Nursing* See: <http://tcn.sagepub.com/content/early/2014/10/07/1043659614553515> (accessed 20 July 2015).
- Ergenekon-Ozelci P, Elmaci N, Ertem M, Saka G. (2006) Breastfeeding beliefs and practices among migrant mothers in slums of Diyarbakir, Turkey. *European Journal of Public Health* 16(2): 143-8.
- Fischer TP, Olson BH. (2014) A qualitative study to understand cultural factors affecting a mother's decision to breastfeed or formula feed. *Journal of Human Lactation* 30(2): 209-16.
- Foo LL, Quek SJ, Ng SA, Lim MT, Deurenberg-Yap M. (2005) Breastfeeding prevalence and practices among Singapore Chinese, Malay and Indian mothers. *Health Promotion International* 20(3): 229-37.
- Gardenswartz L, Rowe A, Digh P, Bennet M. (2003) *The global diversity desk reference: managing an international workforce*. Pfeiffer: San Francisco.
- Glover M, Waldon J, Manaena-Biddle H, Holdaway M, Cunningham C. (2009) Barriers to best outcomes for Maori: mothers' perceptions, Whanau perceptions and services. *Journal of Human Lactation* 25(3): 307-16.
- Hammer MR. (2011) Additional cross-cultural validity testing of the Intercultural Development Inventory. *International Journal of Intercultural Relations* 35: 474-87.
- Hangchaovanich Y, Voramongkul N. (2006) Breastfeeding promotion in Thailand. *Journal of the Medical Association of Thailand* 89(4): 173-7.
- Hofstede G. (1980) *Culture's consequences*. Sage: Beverly Hills.
- Hofstede G. (2001) *Culture's consequences: comparing values, behaviours, institutions and organisations across nations*. Sage: Thousand Oaks.
- Im E. (2015) What makes an intervention culturally appropriate? *Journal of Transcultural Nursing* 26(1): 5.
- International Baby Food Action Network. (2012) *The convention on the rights of the child: report on the situation of infant and young child feeding in Thailand*. See: [ibfan.org/art/IBFAN\\_CRC59\\_Thailand-2012.pdf](http://ibfan.org/art/IBFAN_CRC59_Thailand-2012.pdf) (accessed 20 July 2015).
- Jezewski MA. (1990) Culture brokering in migrant farmworker health care. *Western Journal of Nursing Research* 12(4): 497-513.
- Johnston ML, Eposito N. (2007) Barriers and facilitators for breastfeeding among working women in the United States. *Journal of Obstetric, Gynecologic and Neonatal Nursing* 36(1): 9-20.
- Kaewsarn P, Moyle W. (2000) Cultural beliefs and breastfeeding duration of Thai working women. *Breastfeeding Review* 8(1): 13-7.
- Keller JM. (2010) *Motivational design for learning and performance: the ARCS model approach*. Springer: New York.
- Kelly YJ, Watt RG, Nazroo JY. (2006) Racial/ethnic differences in breastfeeding



## References continued

- initiation and continuation in the United Kingdom and comparison with findings in the United States. *Pediatrics* 118(5): 2207-8.
- Knafo A, Roccas S, Sagiv L. (2011) The value of values in cross-cultural research: a special issue in honour of Shalom. *Journal of Cross-Cultural Psychology* 42(2): 178-85.
- Manderson L. (1981) Roasting, smoking and dieting in response to birth. *Social Science and Medicine – Part B: Medical Anthropology* 15(4): 509-20.
- McInnes RJ, Hoddinot P, Britten J, Darwent K, Craig LCA. (2013) Significant other, situations and infant-feeding behaviour change processes: a serial qualitative interview study. *BMC Pregnancy and Childbirth* 13: 114.
- Ministry of Public Health. (2006) *Health policy in Thailand*. See: <http://bps.ops.moph.go.th/HealthPolicy6.pdf> (accessed 20 July 2015).
- National Statistical Office. (2007) *Final report: the multiple indicator cluster survey (MICS)*. National Statistical Office: Bangkok.
- Ong SF, Chan WS, Shefaly S, Chong YP, Klainin-Yobas P, He G. (2014) Postnatal experiences and support needs of first-time mothers in Singapore: a descriptive qualitative study. *Midwifery* 30(6): 772-8.
- Oyserman D, Coon HM, Kimmelmeier M. (2002) Rethinking individualism and collectivism: evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin* 128(1): 3-72.
- Parks M, Chesla C. (2007) Revisiting confucianism as a conceptual framework for Asian family study. *Journal of Family Nursing* 13(3): 293-311.
- Persad MD, Mesinger JL. (2007) Maternal breastfeeding attitudes: association with breastfeeding intent and sociodemographics among urban primiparas. *Journal of Community Health* 33(2): 53-60.
- Phouthakeo P, Otsuka K, Ito C, Sayamoungkhoun P, Kounnavong S, Jimba M. (2013) Cross-border promotion of formula milk in Lao People's Democratic Republic. *Journal of Paediatrics and Child Health* 50(1): 51-6.
- Rohan M. (2000) A rose by any name? The values construct. *Personality and Social Psychology Review* 4(3): 255-77.
- Sagiv L, Schwartz SH. (2007) Cultural values in organisations: insights for Europe. *European Journal of International Management* 1(3): 176-90.
- Salguero CP. (2003) *A Thai herbal: traditional recipes for health and harmony*. Findhorn Press: Findhorn Forres, Scotland.
- Salguero CP. (2007) *Traditional Thai medicine: buddhism, animism, ayurveda*. HOHM Press: Prescott, AZ.
- Sansone C, Harackiewicz JM. (2000) *Rewarding competence: the importance of goals in the study of intrinsic motivation*. In: Sansone C, Harackiewicz JM. (Eds.). *Intrinsic and extrinsic motivation: the search for optimal motivation and performance*. Academic Press: San Diego: 82-96.
- Schwartz SH. (1999) Cultural value differences: some implications for work. *Applied Psychology: An International Review* 48: 23-48.
- Schwartz SH. (1992) Universals in the content and structure of values: theoretical advances and empirical tests in 20 countries. *Advances in Experimental Social Psychology* 25: 1-65.
- Schwartz SH. (1990) Individualism-collectivism: critique and proposed refinements. *Journal of Cross-Cultural Psychology* 21(2): 139-57.
- Segawa M. (2008) Buddhism and breastfeeding. *Breastfeeding Medicine* 3(2): 124-8.
- Spatz DL. (2004) Ten steps for promoting breastfeeding for vulnerable infants. *The Journal of Perinatal and Neonatal Nursing* 18(4): 385-96.
- Stockdale J, Sinclair M, Kernohan WG, Keller JM, Dunwoody L, Cunningham JB, Lawther L, Weir P. (2008) Feasibility study to test 'designer breastfeeding': a randomised controlled trial. *Evidence Based Midwifery* 6(3): 76-82.
- Stockdale J, Sinclair M, Kernohan WG, Keller J. (2011) *Understanding motivational theory and psychology of breastfeeding*. In: Bryar R, Sinclair M. (Eds.). *Theory of midwifery practice*. Palgrave Macmillan: Basingstoke: 92-112.
- Stockdale J, Sinclair M, Kernohan WG. (2014) Applying the ARCS design model to breastfeeding advice by midwives in order to motivate mothers to personalise their experience. *Evidence Based Midwifery* 12(1): 4-10.
- Sutton J, Meizi H, Despard C, Evans A. (2007) Barriers to breastfeeding in a Vietnamese community: a qualitative exploration. *Canadian Journal of Dietetic Practice and Research* 68(4): 195-200.
- Tarrant M, Dodgeson JE, Fei ST. (2004) Becoming a role model: the breastfeeding trajectory of Hong Kong women breastfeeding longer than six months. *International Journal of Nursing Studies* 41(5): 535-46.
- Teich AS, Barnett J, Bonuck K. (2014) Women's perception of breastfeeding barriers in early postpartum period: a qualitative analysis nested in two randomised controlled trials. *Breastfeeding Medicine* 9(1): 9-15.
- Thomas M, Avery V. (1997) *Infant feeding in Asian families: early practices and growth*. HMSO: London.
- Trading Economics. (2014) *Exclusive breastfeeding (% of children under six months) in Thailand*. See: [tradingeconomics.com/thailand/exclusive-breastfeeding-percent-of-children-under-6-months-wb-data.html](http://tradingeconomics.com/thailand/exclusive-breastfeeding-percent-of-children-under-6-months-wb-data.html) (accessed 20 July 2015).
- Triandis HC, Chan DK, Bhawuk DPS, Iwao S, Sinha JB. (1995) Multi-method probes of allocentrism and idiocentrism. *International Journal of Psychology* 30(4): 461-80.
- Trickett EJ. (2009) Community psychology: individuals and interventions in community context. *Annual Review of Psychology* 60: 395-419.
- Unger JB, Schwartz SJ. (2012) Conceptual considerations in studies of cultural influences on health behaviour. *Preventative Medicine* 55(5): 353-5.
- United Nations Children's Fund. (2013) *State of the world's children*. UNICEF: New York.
- Waterman AS. (1984) *The psychology of individualism*. Praeger: New York.
- Whiting BB. (1976) *The problem of the packaged variable*. In: Riegel KE, Meachams JA. (Eds.). *The developing individual in a changing world*. Aldine: Chicago.
- Williams RM. (1970) *American society: a sociological interpretation (third edition)*. Knopf: New York.
- The World Bank. (2013) *Thailand overview*. See: [worldbank.org/en/country/thailand/overview](http://worldbank.org/en/country/thailand/overview) (accessed 20 July 2015).
- World Breastfeeding Trends Initiative. (2010) *Country name: Thailand*. See: <http://worldbreastfeedingtrends.org/report/WBTI-Thailand-2010.pdf> LINK BROKEN Should this be: <http://www.worldbreastfeedingtrends.org/GenerateReports/countrysubmit.php?country=TH> (accessed 20 July 2015).
- WHO. (2014) *The World Health Organization's infant-feeding recommendations*. WHO: Geneva.
- WHO. (2002) *Complementary feeding: report of the global consultation and summary of guiding principles for complementary feeding of the breastfed child*. WHO: Geneva.
- WHO. (1998) *The world health report – life in the 21st century: a vision for all*. WHO: Geneva.
- WHO. (1981) *International code of marketing of breastmilk*. WHO: Geneva.
- WHO, UNICEF. (2013) (1989??) *Ten steps to successful breastfeeding*. [tensteps.org](http://whqlibdoc.who.int/publications/9241561300.pdf) (accessed 20 July 2015) <http://whqlibdoc.who.int/publications/9241561300.pdf> in *Protecting, promoting and supporting breastfeeding: the special role of maternity services*.
- Yimyam S, Hanpa W. (2014) Developing a workplace breastfeeding support model for employed lactating mothers. *Midwifery* 30(6): 720-4.